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Oh behalf of the Kansas Health Care Association and Kansas Center for Assisted Living we would like to submit some suggestions on improving the Medicaid program.

Nursing Homes-

Reduce home equity limit in Medicaid, and require people to take out a reverse mortgage and pay Medicaid before entering the program.

Strengthen the enforcement of estate recovery in Medicaid.

Medicaid should be the first reimbursed when a lawsuit is settled. Often times the people who bring the lawsuits against providers are family members who have had little or no relationship with the plaintiff and Medicaid should be reimbursed for expenses before family members are rewarded. Several states have this in their statutes including Idaho.

All nursing homes in Kansas should be Medicare and Medicaid certified. So when someone wants to use their Medicare as the first payer they have the option.

Programs to keep individuals from hospitals or re-hospitalization

The dual-eligible seniors are the expensive group so does this group need to be federalized?

Senior Care Organizations (SCO's) pilot in Kansas
Pilots through a section 1115c waiver, are currently working in Massachusetts and Minnesota. Explainer on SCO's is attached. Minnesota through its Senior Health Options program integrates Medicare and Medicaid services. (KHPA Medicaid Savings Option, March 2010 had a notation on page 21)

Expand PACE Programs to mid-sized communities i.e. Manhattan, Salina, Hutchinson and into for-profit provider networks

Review Kansas incentives for individuals to purchase long term care insurance

Insurance exchanges could be sellers of Long Term Care Insurance

Create community Wellness programs around the long term care homes

Assisted Living-

Create tiered payment system for state licensed only homes (i.e. Assisted Living). Current system based on care units which requires excessive documentation.

Benefits of a tiered system
Stabilized funding for providers
Increase access to appropriate level of care for impoverished seniors

Decreased documentation time equals increased resident care time
appropriate oversight for care and quality assurance

Obtain housing vouchers or subsidies for Medicaid residents in Assisted Living... could be a pilot.

Propose an audit of true costs of HCBS self-directed services in comparison with long term care services.

Overall areas of reform-

Develop and promote relationships between the small rural hospitals and LTC Facilities, i.e. joint purchasing and staffing needs.

Create Administrator Pilot Program for Rural areas to allow nurses to become administrators without a four year degree.

Offer incentives to out of state administrators in good standing to move to Rural Kansas.

Reinstate Certificate of Need

Set limitation on unknown providers and non-vetted providers

Set criteria for untried providers coming into Kansas with waiting period and stepped up survey procedures for at least two years. Other states have something similar to this and restrict out of state providers.

Increase the number of tele-health pilots around the state of Kansas for preventative monitoring and mental health access

More focus on oral health care because this reduces the unnecessary hospitalizations

Develop a pilot to go seamlessly between nursing home providers and the need of those in Home and Community Based Services. Nursing homes could be the central clinic of a community.

Home delivered meals such as Meals on Wheels could be provided from the local nursing home. Many centers already supply meals to the community. So in this tough economic time let the local kitchens provide the community their meals also.

Submitted by

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Summary of the Senior Care Options (SCO) Program in Massachusetts

The SCO program is a unique, research and demonstration project managed by MassHealth and funded through a section 1115C waiver approved by the federal Centers for Medicare & Medicaid Services (CMS). Massachusetts is one of only two states in the country (Minnesota is the other) that has established a SCO program. The program is open on a voluntary basis to dual-eligibles (Medicare and Medicaid) age 65 and over. Approximately 13,000 of the 110,000 dual-eligibles age 65 and over have been enrolled in SCOs.

Under the SCO program, the state contracts with select senior care organizations to provide all acute, primary, and long term care services to enrolled dual-eligibles. SCOs receive separate Medicare and Medicaid monthly capitations that are combined at the contractor level. They then have maximum flexibility to provide whatever services enrollees need without worrying about individual payer policies. Medicare capitations are individual diagnosis-based rates per the Medicare Advantage plans, and Medicaid capitations are based on 24 different rating categories supporting all levels of care in community and nursing facility settings. SCO beneficiaries have individualized care plans, 24/7 access to nurse management services, choice of primary care physician/team, relief from Medicare and Medicaid paperwork and screenings. "extra" benefits not available in fee-for-service plans, and access to a wide network of acute, primary, and long term care providers. There are no co-payment responsibilities.

Currently there are four SCO contractors in the Commonwealth covering all regions of the state except for the Berkshires and Cape Cod. Three were awarded contracts at the inception (Evercare, Senior Whole Health, and Commonwealth Care Alliance) and a fourth (Fallon Community Health Plan) was added just recently. The SCO objectives are to align Medicare and Medicaid financing incentives, establish accountability for delivery, coordination, and management of quality health care to high-risk dual-eligible seniors, attempt to maintain seniors longer in their homes and communities by integrating all aspects of acute, primary, and long term care, and achieve cost savings over time through prevention of disability and deterioration.

Early evaluations have given the SCOs high grades for consumer satisfaction. A 2009 evaluation by JEN Associates indicated that SCOs have been successful in reducing nursing facility utilization for custodial care but increasing nursing facility usage for post-acute care. SCOs seem to have been successful in maintaining more frail populations in the community, and the SCO population that uses nursing facilities is frailer than the level seen in comparative non-SCO populations. SCOs have been quite successful in reducing hospitalization (and re-hospitalization) rates through the expanded use of nurse practitioners and other chronic care management strategies, and some of those savings have been shifted to the long-term care side of the operation (see next paragraph).

On balance, nursing facility providers give the SCOs positive grades for quality, access, and reimbursement. SCOs pay nursing facilities the case-mix adjusted fee-for-service Medicaid rate plus 2% and provide a broader service base including dental and podiatry care. SCOs have not engaged in selective contracting and volume pricing practices. They are still in the marketing stage of development and appear willing to have wide provider networks. While nursing facility providers recognize that SCOs have as a fundamental goal the reduction of custodial nursing facility days, they welcome the growth of higher margin subacute care days. To quote from the JEN report, "SCO enrollees are more likely to use a nursing facility for extended rehabilitation and end of life care and less likely to stay in a nursing facility beyond 4 months" The only common concern that nursing facility providers have regarding SCOs relates to their aggressive case management and shorter overall Medicare-funded lengths of stay. Those stays appear to be about one-half the duration of traditional Medicare fee-for-service length of stays.